DOCUMENT RESUME

ED 448 880 PS 029 105

AUTHOR Stemmler, Peggy; Naimark, Dana Wolfe
TITLE Make Kids Count: Closing the Gap in Children's Health Coverage.
INSTITUTION Children's Action Alliance, Phoenix, AZ.
PUB DATE 2000-05-00
NOTE 54p.; The Murphy Memorial, a fund of St. Luke's Charitable Health Trust, provided financial support.
AVAILABLE FROM Children's Action Alliance, 4001 North 3rd Street, Suite 160, Phoenix, AZ 85012. Tel: 602-266-0707; Fax: 602-263-8792; e-mail: caa@azchildren.org; Web Site: http://www.azchildren.org.
PUB TYPE Reports - Evaluative (142)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Change Strategies; Child Health; *Children; Health Care Costs; *Health Insurance; Health Programs; Health Services; Program Effectiveness; State Federal Aid; *State Programs; Trend Analysis
IDENTIFIERS *Arizona; *Childrens Health Insurance Program

ABSTRACT

The Children's Health Insurance Program (CHIP) in Arizona is called KidsCare. This report provides a portrait of children's health coverage in the state after a year of operation of KidsCare. Following an executive summary, the first section of the report presents overall statistics and trends in children's health coverage. The second section explores issues in employment-based health insurance, and the third section describes existing publicly-funded health care services for children in Arizona. Finally, the fourth section identifies the continuing gaps in children's health coverage (system gaps, population gaps, and service/coverage gaps) and provides recommendations to help close those gaps and reduce the number of uninsured children. A few of the recommendations are: (1) work to fully enroll eligible children in the available programs; (2) offer premium subsidies to families; and (3) maximize state health dollars by leveraging federal money to fund health coverage. (Contains 41 endnotes.) (EV)

Reproductions supplied by EDRS are the best that can be made
from the original document.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Make Kids Count

Closing the Gap in Children's Health Coverage

ED 448 880

PS 029105

May 2000
Children's Action Alliance

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

D. Naimark

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

BEST COPY AVAILABLE

Make Kids Count

Closing the Gap in Children's Health Coverage

May 2000
Children's Action Alliance

About Children's Action Alliance

Children's Action Alliance (CAA) is a nonprofit, nonpartisan research, education and advocacy organization dedicated to promoting the well-being of all of Arizona's children and families. Through research, publications, media campaigns and advocacy, we act as a strong and independent voice to make children a top priority in Arizona. Our fundamental goal is to bring about a greater understanding by policymakers, business leaders, the media and the general public of the high economic and social stake that all Arizonans have in the well-being of our children.

CAA Board of Directors

Nadine Mathis Basha, President
The Honorable Dan Schweiker, Past President
Laura Treman Almquist
David Bodney
Amy Carlile
Kay Ekstrom
Armando Flores
Jaime P. Gutierrez
Nora Hannah
David Howell
Andy Hurwitz
Derrick Johnson
Martin E. Latz
Steve Lynn
Bruce Merrill, Ph.D.
Elizabeth Hernandez McNamee
Patricia Montiel Overall, Ph.D.
Barbara Polk
Steve Roman
Michael Smith
Alice Snell
Jacque Steiner
Jerry Ward
Carolyn Warner

Executive Director
Carol Kamin, Ph.D.

Copyright May 2000
Children's Action Alliance

Any or all portions of this report may be reproduced without prior permission, provided the source is cited as *Closing the Gap*, Children's Action Alliance, 4001 North Third Street, Suite 160, Phoenix, Arizona, 85012.

Acknowledgements

Children's Action Alliance gratefully acknowledges the support of the following individuals and organizations who made this report possible.

The Murphy Memorial,
a fund of St. Luke's Charitable Health Trust
for financial support

The Robidoux Foundation
for the design of this publication

Anne Thompson
for her editing assistance

Special Thanks

The work of many people went into this report. We would like to acknowledge our consultant, Ami Nagle, for collecting and compiling information used in this report.

The following experts on health care in Arizona were interviewed for this report:

Barbara Burkholder, Arizona Public Health Association
LeAnn Corbin, American Academy of Pediatrics, Arizona Chapter
Robert Gomez, El Rio Community Health Center
Elizabeth Hernandez McNamee, St. Luke's Charitable Health Trust
Judy Keagy , Children's Clinics for Rehabilitative Services
David Landrith, Arizona Medical Association
Laurie Lange, Arizona Hospital and Healthcare Association
Debbie McCune Davis, The Arizona Partnership for Infant Immunization
Alida Montiel, Inter Tribal Council of Arizona
Mary Rimsza, M.D., Arizona State University
Andy Rinde, Arizona Association of Community Health Centers
Barb Smith, M.D., Children's Clinics for Rehabilitative Services and American Academy of Pediatrics-Arizona Chapter
Diane Zipley, March of Dimes (formerly associated with)

We wish to thank Merrill Krenitz, Elsie Eyer, and Barbara Burkholder for their thoughtful review and comments.

Peggy Stemmler and Dana Wolfe Naimark of Children's Action Alliance researched and authored this report.

Table of Contents

Executive Summary	1
Introduction	5
Chapter 1: Children's Health Coverage: Statistics and Trends	7
Chapter 2: Employment-Based Health Insurance	11
Chapter 3: Publicly Funded Health Care	17
Public Health Insurance	18
Public Health Services and Programs	23
Chapter 4: Gaps in the Health Care System for Children	33
System Gaps	33
Population Gaps	35
Service/Coverage Gaps	37
Recommendations	38

Executive Summary

In 1997, Congress responded to the rising number of uninsured children with a dramatic new policy. The State Children's Health Insurance Program legislation, known as SCHIP, was enacted. The legislation provided federal funding to states that contributed matching funds and that created health coverage programs for children within specified guidelines. Arizona's SCHIP program is known as KidsCare. After one year, it has provided comprehensive health coverage to 29,000 children who would otherwise be uninsured, and it promises to reduce Arizona's high rate of uninsured children, currently the worst rate in the nation. But even after the creation of KidsCare, more than 300,000 children in Arizona remain uninsured and a variety of other critical gaps exist in children's health coverage.

Children's Health Coverage: Statistics and Trends

Two interrelated trends have affected children's health coverage in Arizona and throughout the nation during the 1990s: a decrease in coverage through private health insurance and an increase in eligibility for publicly funded health coverage. Although more than half of all children in Arizona were covered by private health insurance in 1998, 26% were uninsured. This compared with a national rate of 15% of children uninsured.

Employment-Based Health Insurance

Arizona's rate of employment-based health coverage is far below the national average. The percentage of children in Arizona covered through employment-based health insurance fell from 62% in 1987 to 54% in 1999. The drop in employment-based coverage has occurred for many reasons: employers may offer coverage only to full-time workers; the cost-sharing to the employee may be

unaffordable; or the insurer may exclude family members because of preexisting conditions. Low wage workers are the least likely to be offered employment-based health coverage and the least likely to be able to afford to purchase coverage on their own.

Publicly Funded Health Care

A wide variety of publicly funded programs enable hundreds of thousands of Arizona children to access needed health care. These programs serve different populations of children, under different administrative auspices, and offer a variety of services.

Arizona's two main public health insurance programs for children are KidsCare and Medicaid, which is known in Arizona informally as AHCCCS, after the Arizona Health Care Cost Containment System. Begun in 1982, AHCCCS administers Medicaid and provides comprehensive health coverage through private managed care health plans to eligible children. There are virtually no costs to the family. Historically, eligibility was linked to the receipt of welfare. In 1996, through welfare reform, the link between cash welfare and Medicaid was severed. But many residual policy barriers, both perceived and real, remain from that linkage which make it difficult for families to enroll in AHCCCS coverage.

KidsCare provides health insurance through the same provider network as AHCCCS to many children who live in families with incomes below 200% of the federal poverty level (FPL) and who are not eligible for AHCCCS. Families with incomes over 150% of the FPL must pay premiums of $10 to $20 per month.

In addition to these health insurance programs, Arizona has a variety of health services programs that help meet specified health care needs for uninsured children. These include primary care programs funded through the state tobacco tax, Community Health Centers, Children's Rehabilitative Services, the Arizona Early Intervention Program, and Indian Health Services. While these programs offer critical services, they often do not cover specialty or emergency care. The amount of services available is limited, based on appropriated funding.

Gaps in the Health Care System for Children

Even with the variety of health insurance and direct services programs for children in Arizona, thousands of children remain ineligible, and holes in the safety net exist. Identified gaps in children's health coverage are listed below:

System Gaps

- Employment-based coverage is becoming less and less accessible.
- When dependent health coverage is offered, premiums and copayments prevent many families from using it.
- Funding limitations in various programs result in waiting periods or lack of care.
- Complicated and onerous administrative enrollment requirements for some programs keep many parents from getting health coverage for their children.
- Most children who are applying for public or private health insurance coverage are unable to get services immediately.
- There is a significant shortage of health care providers in rural areas, particularly for specialty care.
- The Indian Health System is underfunded.

Population Gaps

- Many parents leaving welfare for work do not know they can keep their children enrolled in AHCCCS or KidsCare.
- Immigrant children in certain circumstances and children of state employees are not eligible for KidsCare, no matter what their income is. Uninsured children with family incomes exceeding 200% of the federal poverty level are also ineligible for KidsCare.
- Children with special health care needs may require services that are not covered adequately by private insurance.
- Migrant, homeless, and runaway children are the least likely to be able to access regular health care.
- Teenagers present a unique set of health care needs that may not be covered by health insurance and that physicians are not trained in providing.
- Minorities are disproportionately represented in the uninsured population, even when job status is taken into account.
- Legal immigrants face specific restrictions on benefits as well as confusion and fear about applying for services.
- Illegal immigrants are ineligible for many health care programs and services.

Service/Coverage Gaps

- There are significant shortages in dental care providers throughout much of the state, and many employment-based insurance packages do not include dental coverage.
- Behavioral health services, which address children's developmental and mental health needs, are limited in scope or duration in KidsCare and in many private health care plans.
- Children with special health care needs may have limited access to pediatric specialty care.
- Insurance plans frequently do not cover services such as prescription drugs, vision, and hearing services.

Closing the Gap

While it would be impossible to completely close every gap in health coverage for every child in Arizona, there are policy steps we can take to close many of those gaps significantly.

1. Work to fully enroll eligible children into AHCCCS and KidsCare.
2. Offer subsidies to help families afford employment-based and other private insurance.
3. Leverage federal dollars for health coverage by expanding Medicaid eligibility for adults or children.
4. Develop and promote health insurance purchasing pools for small businesses, or enable individuals or businesses to purchase health insurance through AHCCCS or through the state employee health plans.
5. Increase funding for Community Health Centers and other safety net providers.
6. Develop a standard child-friendly benefits package for public and private insurance.
7. Align eligibility and enrollment rules among various public programs.
8. Support and evaluate the telemedicine program.
9. Increase health education so that parents know how to best access available services.

Introduction

After proposals for federal health care reform failed in 1994, the attention of policymakers in Arizona and throughout the nation focused on the problem of children with no health insurance. The percentage of children without insurance had been rising steadily, despite significant expansions in Medicaid coverage for children. Changes in the employment-based insurance market meant that more and more children in working families had no health coverage at all.

And the negative consequences were evident. Children without health insurance missed school and fell behind as illnesses got in the way of learning. Parents were forced to miss work to care for their sick children, as untreated illnesses lingered or grew into medical crises. Children suffered permanent damage to their health from conditions that could have been easily treated. Parents were forced to continue to rely on welfare or to leave work and return to welfare because they could not afford health insurance for their children when they were working in low wage jobs. And hospital emergency rooms became a more frequent alternative to primary care for parents who had nowhere else to turn — an alternative that is ultimately more expensive.

In 1997, Congress responded with a dramatic new policy. The State Children's Health Insurance Program legislation, known as SCHIP, was enacted. The legislation provided federal funding to states that contributed matching funds, and that created health coverage programs for children within specified guidelines. By September 1999, almost 2 million children in the United States who would otherwise have been uninsured had comprehensive health coverage through SCHIP programs.

Arizona's SCHIP program is known as KidsCare. After just over one year of operation, it covers 29,000 children. Another 27,000 children have been enrolled in AHCCCS (Arizona's Medicaid program) after applying for KidsCare. KidsCare has created tremendous opportunities to reduce

Arizona's high rate of uninsured children, which is currently the worst rate in the nation, and to improve the health of Arizonans today and in the future.

But more than 300,000 children in Arizona remain uninsured. Thousands of these children are not eligible for KidsCare or AHCCCS. A variety of critical gaps exist in children's health coverage. Now that KidsCare has been in operation for more than a year, this report takes a new look at the portrait of children's health coverage in our state. The first section of the report presents overall statistics and trends in children's health coverage. The second section explores issues in employment-based health insurance. The third section describes existing publicly funded health care services for children in Arizona. And the fourth section identifies the continuing gaps in children's health coverage as well as recommendations to help close those gaps and reduce the number of uninsured children.

chapter 1

Children's Health Coverage: Statistics and Trends

In the past decade, the United States has faced an alarming growth in the number of uninsured children and adults. In Arizona, the trend has paralleled that in the nation as a whole, but at a higher rate. The proportion of Arizonans who are uninsured is second highest in the country.[1] Both nationally and in Arizona, the increase in the number of people without health insurance reflects the changing job market and diminishing access to employment-based health coverage. Most of the uninsured live in households where one or more adults are employed.

Children's Health Coverage Trends

Two interrelated trends have impacted children's health coverage in Arizona during the 1990s: a decrease in coverage through private health insurance and an increase in eligibility for publicly funded health coverage.

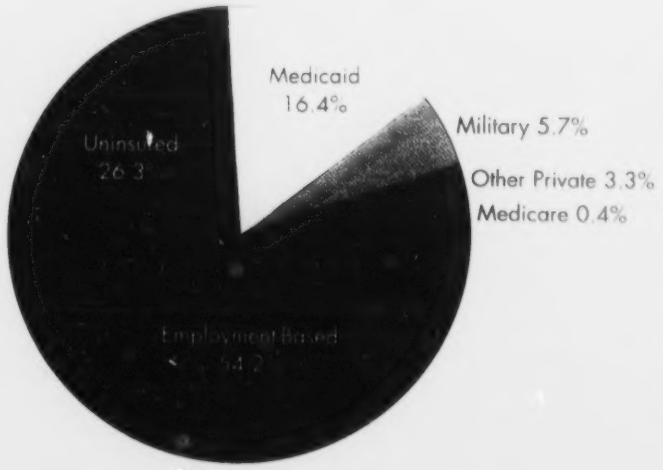
Between 1989 and 1995, the percentage of children covered by employment-based insurance decreased from 58.1% to 53.1% of all Arizona children, and the percentage covered by other private insurance dropped from 12.6% to 4.8%.[2] At the same time, the percentage of children covered by government-provided health insurance increased from 17.5% to 27.2%. But this increase could not make up for the loss of private insurance. The rate of uninsured children rose from 18.3% in 1989 to 22.8% in 1995. (See Figure 1)

In 1998, the majority of Arizona children had some type of health coverage. According to data from the Current Population Survey (U.S. Census Bureau), 57.5% of children were covered by private health insurance, either through an employer or individually purchased coverage. In addition, 22.5% of children had government-sponsored coverage through Medicaid, Medicare, or military health care.[3]

FIG 1: **HEALTH INSURANCE COVERAGE OF ARIZONA CHILDREN UNDER AGE 18**

Source: Calculation based on 5-year averages of data from the *Current Population Survey*, U.S. Census Bureau, (average 1987-1991) (average 1993-1997).

FIGURE 2: **CHILDREN'S HEALTH COVERAGE IN ARIZONA 1998**



Source: Annual Supplement, *Current Population Survey*, U.S. Census Bureau, March 1999.
Because a child may have more than one form of coverage, the total is greater than 100%.

BEST COPY AVAILABLE

However, more than one in five children in Arizona—26.3%—were uninsured. This compares with a national rate of 15.4%. More than 90% of these uninsured children had one or more working parents; employment-based insurance for the children was either unavailable or unaffordable. (See Figure 2.)

What Health Coverage Means for Children

Private health insurance

There is great diversity in the quality and level of health coverage through private health insurance. Private health insurance plans vary in form. They include traditional indemnity plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service plans (POS). These plans are available for purchase through employer groups or by individuals.

Over 1,000 private health insurance companies offer coverage in Arizona. In addition, many large businesses are self-insured, assuming the financial risks for coverage within the organization. State law requires that a basic benefit plan include a standard base of services. However, specific insurance plans vary in the degree to which these services are paid for by insurance, and in the level of costs paid by the family in the form of premiums, co-payments, or deductibles. Thus, even a family with private health insurance for their children may find that specific health care services are uncovered and unaffordable.

Uninsured

Health insurance directly affects access to health care, and indirectly affects health status. Uninsured people are more likely to delay seeking health care, less likely to have a regular source of medical care, and more likely to receive care in emergency departments or hospital outpatient clinics.[4] Delays in seeking care result in increased rates of hospitalization for conditions that can generally be treated in the outpatient setting.

The assertion is often made that uninsured people can always find medical treatment, if necessary. The evidence, however, shows that insurance significantly affects access to health care and health outcomes. The American College of Physicians-American Society of Internal Medicine recently reviewed a decade of literature linking health insurance with access to health care and health outcomes.[5] They conclude that

> *Arguments that uninsured Americans receive the same levels of medical care as insured Americans, despite their lack of coverage, are contradicted by these studies. Research has clearly demonstrated that having health insurance makes a difference in health care for Americans. The uninsured...get less health care than those who have insurance.*
>
> *...A lack of insurance is associated with a delay in seeking care, disease progression, and reduction of the likelihood of a favorable outcome or survival.*

These conclusions reflect earlier data from Arizona. In 1995, a survey of Arizonans showed that "insurance is the key variable in getting health care services for [chronically uninsured] children." Unlike the state's lowest income children, who are enrolled in the AHCCCS program, and who saw a doctor as frequently as those with private insurance coverage, over half of children who were uninsured for more than two years had not seen a doctor in the past year, and nearly 1 in 5

reported no usual source of health care.[6] A separate analysis of the same data showed "nearly 60% of Arizona's uninsured reported not having seen a doctor in the prior year, and almost half of those said they had put off or postponed getting needed medical care for financial reasons."[7]

Uninsured people also receive a different quality of care. They are less likely to undergo expensive testing and more likely to be sent home from the hospital sooner than insured persons with similar conditions.[8] In addition, uninsured children lack access to preventive and acute care services. The facts are clear: Insurance makes a positive difference in health care.

The Safety Net

Health care options for people without insurance are sometimes called the safety net, available to catch people before they fall. The health care safety net is a diverse set of people, places, and programs that provide health care to the uninsured. The safety net is woven with varying threads of support: private funding and services, individual payments, state and federal subsidies, and subsidies drawn from private insurance premiums. Shaped by local political forces and funding, Arizona's safety net is uncoordinated, geographically uneven, and full of holes. But with more than half of Arizona's children poor or near poor, and a low rate of employment-based insurance, the strength of the safety net is critical to the health of uninsured children and underinsured children who need supplemental services.

Access to Insurance for the Uninsured

More than 80 percent of Arizona's uninsured children live in households with incomes below 200% of the Federal Poverty Level (FPL), or $34,100 per year in a family of four.[9] In Arizona and throughout the nation, thousands of uninsured children are actually income-eligible for publicly funded health coverage, but not enrolled. It is estimated that 53% of Arizona's uninsured children are income-eligible for the Arizona Health Care Cost Containment System (AHCCCS), and 30% are income-eligible for KidsCare, Arizona's Children's Health Insurance Program. (See Figure 3.)[10] But even if all these children were enrolled in coverage, more than 60,000 children would remain uninsured in families who earn too much to qualify for either AHCCCS or KidsCare.

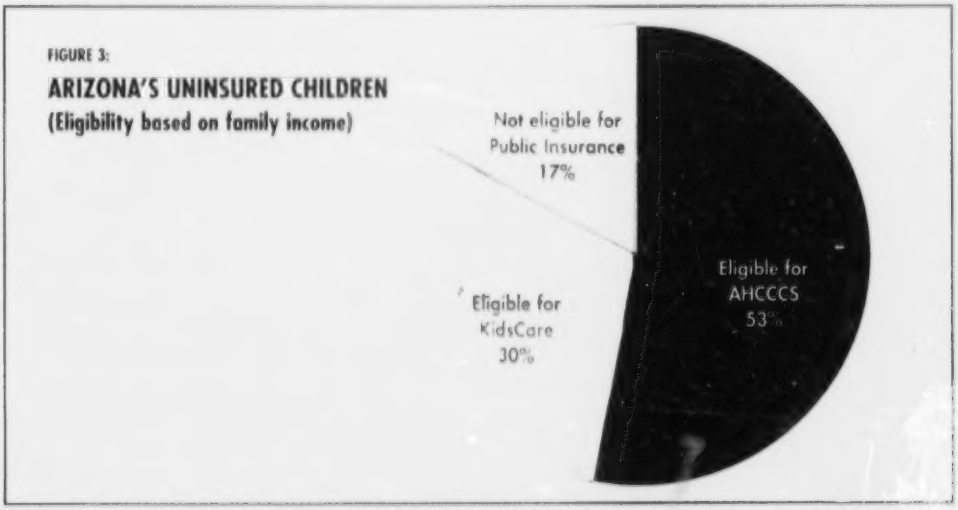


FIGURE 3:
ARIZONA'S UNINSURED CHILDREN
(Eligibility based on family income)
Not eligible for Public Insurance 17%
Eligible for AHCCCS 53%
Eligible for KidsCare 30%

Source: American Academy of Pediatrics Division of Health Policy Research. *Program Eligibility of Uninsured Children through Age 18: Year 2000 Projection*

chapter 2

Employment-Based Health Insurance

Employment-based health insurance remains the most common vehicle for health coverage for children. Indeed, more than half of all children in Arizona receive health insurance through a parent's or guardian's employer. While there is great variation in types of employment-based insurance, general trends such as the growth of managed care and increasing health care costs have shaped the entire industry. Not only is the rate of children's health coverage through employers falling, but the number of employees covered through employment-based health insurance is declining despite our strong economy.

There are a number of federal tax policies that promote private employment-based coverage. The cost of these policies in 1998 was $111.2 billion in lost tax revenue, through tax exemptions for health insurance premiums and out-of-pocket expenditures, and through tax-exempt flexible spending plans.[1] These tax policies subsidize health coverage for families with higher incomes; such families are more likely to have employment-based coverage, to itemize deductions, and to take advantage of flexible spending plans.

Some of the data below are based on the coverage status of the employee. Where it is available, information on the children living with the employee is used.

Trends in Employment-Based Health Care

For the last decade, Arizona has been on the forefront of the most significant trend in employment-based health insurance coverage: the shift to managed care. In 1995, about 63% of Arizona residents with employment-based health insurance were enrolled in managed care plans, up dramatically from 39% in 1989.[2]

A second, important trend in employment-based coverage is the reduction in the number of children receiving insurance through their parents' employers. In the mid-1990s, the national rate of employment-based health coverage for children reached a low of 57%. By 1999, however, the national rate had rebounded to 63%. In Arizona, employment-based coverage rates have remained lower. In 1987, 62% of Arizona children had employment-based health insurance. In 1999, only 54% of Arizona children had employment-based insurance.[13]

The drop in employment-based coverage has occurred for several reasons. Employers may offer coverage only to full-time workers; the cost-sharing to the employee may be unaffordable; or the employer or insurer may exclude family members because of preexisting conditions. An increased use of outsourcing and consultants also decreases the number of employees eligible for coverage. In addition, some employers cannot afford to offer health insurance to their employees, leaving both employees and their dependents without coverage.

Who Has Access to Employment-Based Health Coverage?

The availability of employment-based coverage is directly linked to several characteristics of the employer and the job: the size of the company, full-time vs. part-time status, and wage levels.

Size of Company

Employment-based health coverage is much more likely to be offered by large employers than small employers. Nationally, in firms with fewer than 100 employees, about 60% of employees reported having coverage through their own, or a spouse's, employer in 1995. That coverage rate increased to 84% for employees in firms with more than 100 employees.[14] In Arizona, there is a similar differential in coverage between smaller and larger firms, although, overall, the employment-based insurance rates are lower. In Arizona, 52% of workers who were employed by firms with 100 or fewer employees were covered by employment-based insurance, either their own or a spouse's. In firms with more than 100 employees, the coverage rate increased to 79%.[15] (See Figure 4.) Employment statistics from the Department of Economic Security show that nearly half of employed Arizonans work in firms with fewer than 100 employees.

Wages

Low-wage workers in both large and small businesses are the least likely to be offered employment-based health coverage, and the least likely to purchase coverage that is offered. One analysis of national data from 1996 found that only 55% of workers earning less than $7 per hour had access to health coverage through the job (either their own employer or that of a family member), and only 42% were ultimately covered. This compares to a 96% offer and 90% take-up rate for employees earning over $15 per hour.[16] (See Figure 5.)

Employment Status of Parent

It is much more likely that the children of a full-time worker will be covered by employment-based health insurance than children of a part-time worker. In 1995, 64% of Arizona's children with a parent working full-time were covered by employment-based insurance, whereas only 25% of children who had a parent working part-time were covered by employment-based health insurance.[17] (See Figure 6.)

Figure 4: WORKERS IN LARGE FIRMS ARE MORE LIKELY TO BE INSURED

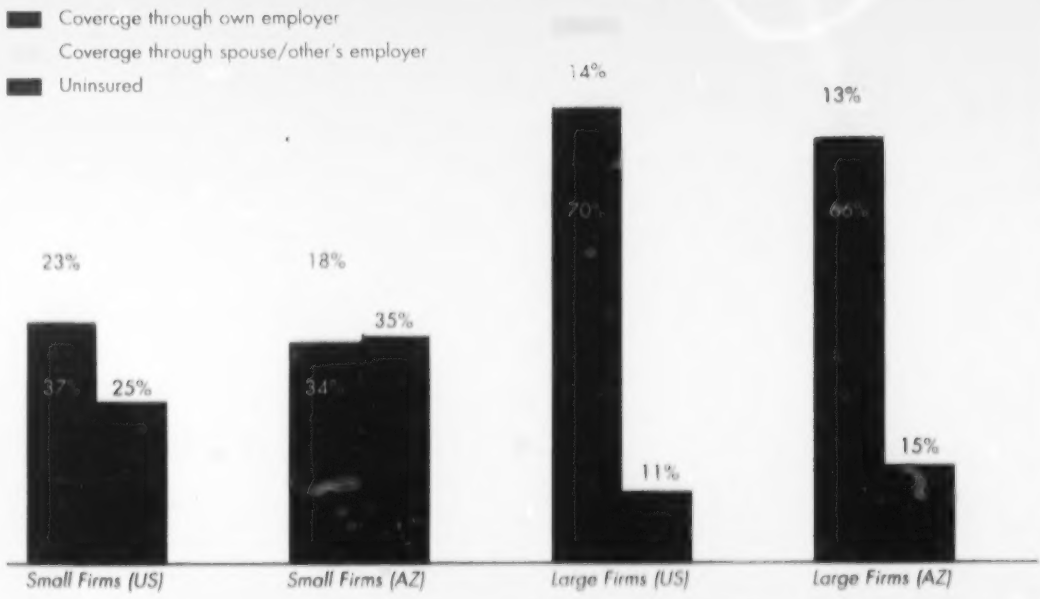


FIG 5: HIGH-WAGE WORKERS MORE LIKELY TO HAVE ACCESS TO EMPLOYMENT-BASED COVERAGE

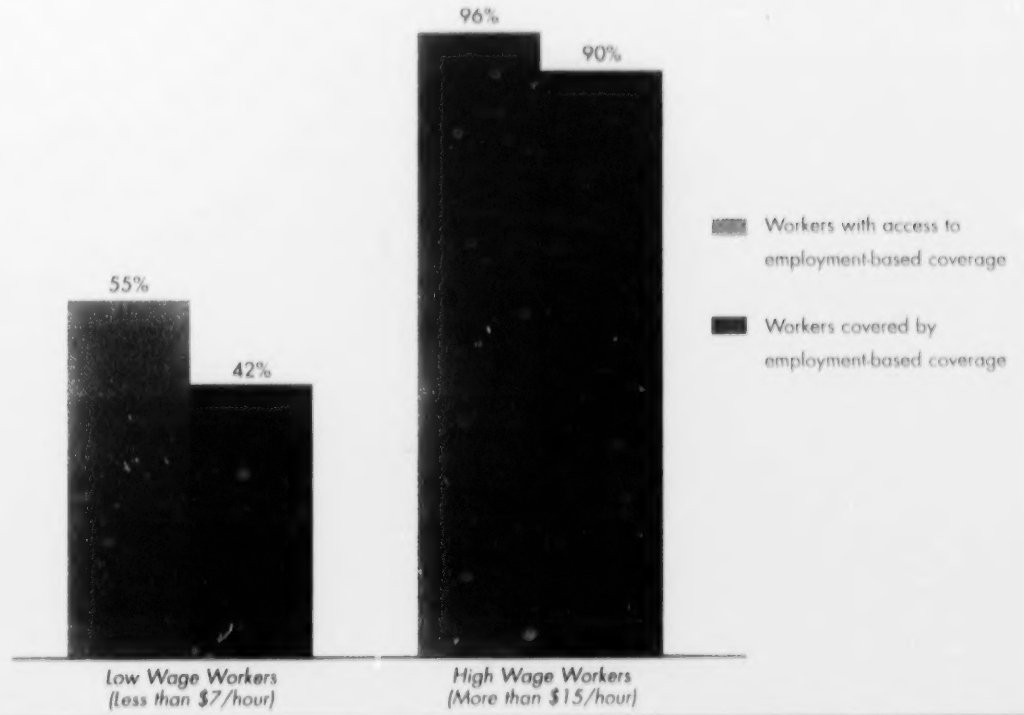
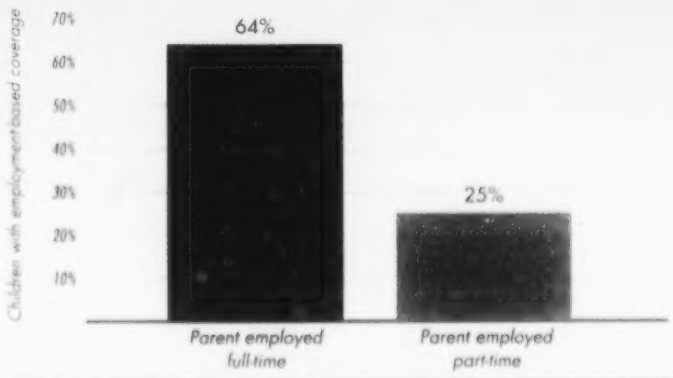


Figure 4 source: *State Level Databook on Health Care and Financing*, Urban Institute, 1998
Figure 5 source: Cooper and Schone, *Health Affairs*, 1997

FIGURE 6: **CHILDREN OF FULL-TIME WORKERS ARE MORE LIKELY TO HAVE EMPLOYMENT-BASED COVERAGE**



Source: Calculations based on data from: Kirkman-Liff, B. *Health Insurance Coverage in Arizona: A Detailed Analysis*. 1996.

Employment-Based Coverage Limitations

Even when employers offer dependent health coverage, families may experience coverage gaps. These gaps include: inability to access coverage due to costs, job transitions with associated waiting periods prior to eligibility, exclusions for pre-existing conditions, and benefit plans that do not reflect children's needs.

Cost-sharing Requirements

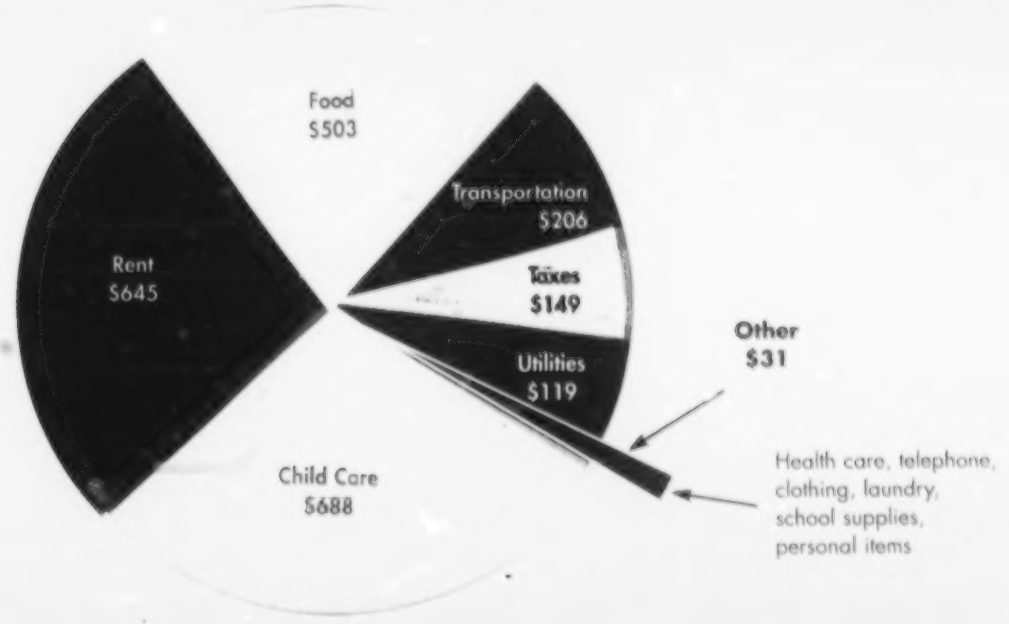
As employers are faced with increasing costs of coverage, they tend to keep their financial contribution to coverage stable, and pass along the residual cost increases to their employees. In firms with more than 100 employees, the average monthly premium contributions paid by the employee for family coverage increased 79% between 1988 and 1993.[18] In a separate analysis, firms with more than 1,000 employees faced a 64% increase in premium costs to the employee between 1990 and 1993.[19] These increased costs adversely affect an employee's ability to enroll in coverage.

Research indicates that families are very sensitive to their out-of-pocket costs for health care. As health insurance premiums increase, families are less likely to purchase insurance. This is especially true for lower-income families. Several states have studied the impact of cost-sharing on health insurance program participation. A study of a public health care plan for low-income people in Washington found that a $10 increase in the monthly family premium reduced the likelihood of enrollment by 13%.[20] An Urban Institute study of premium levels in three states found that when families were charged 1% of income, 57% of uninsured families participated. When these families were charged 3% of income, 35% participated. When the cost-sharing was increased to 5% of income, only 18% participated.[21]

It is not only low wage earners who find health care premiums and deductibles unaffordable. Many families with slightly higher incomes face similar barriers. Figure 7 illustrates a monthly budget for a family of four earning $28,080 per year (165% of the 2000 Federal Poverty Level). For that family, health coverage priced at 5% of their gross family income would cost $117 per month. Yet

FIGURE 7: MANY WORKING FAMILIES CAN'T PAY FOR HEALTH COVERAGE

A married couple with 2 children — a 3-year-old and a 7-year-old.
Each parent works full time and earns $6.75 per hour for an annual household income of $28,080.



Major Monthly Expenses

Earnings are $2,341 placing this family at 170% of the federal poverty level. This family earns too much to qualify for food stamps or a child care subsidy.

Taxes consume 6% of monthly earnings including federal income taxes, Social Security, Medicare, and Arizona's income taxes — less the Earned Income Tax Credit and Child Tax Credit.

Rent costs 28% of monthly earnings for a two-bedroom apartment at fair market rate for the Phoenix metropolitan area in 1997 (Maricopa Association of Governments, October 1998). Converted to 1999 dollars using the Consumer Price Index.

Food consumes 21% of monthly earnings based on the U.S. Department of Agriculture's Low Cost Plan for one adult couple, a 3-year-old and a 7-year-old child (March 1999).

Child care costs 29% of monthly earnings at the median cost of approved home-based care in Maricopa County for one child full time and one child after school. Rates reported in the *Child Care Market Rate Survey, 1998* (Maricopa County Office of Research and Reporting, December 1998).

Transportation costs 9% of monthly earnings based on *half* the average cost to run one car that is more than 10 years old and has 100,000 miles. Estimate includes fuel, tires, repairs, insurance, and taxes and has been converted to1999 dollars using the Consumer Price Index (John E. Schwartz, *Illusion of Opportunity*, 1997).

Utilities consume 5% of monthly earnings based on low-income energy costs by state in 1992 (National Consumer Law Center) converted to1999 dollars using the Consumer Price Index.

Other. 1% of monthly earnings remain to pay for health care, phone, clothing, personal items, school supplies, haircuts, etc.

Source: Children's Action Alliance 1999

the sample family budget shows only $31 remaining in disposable income each month after paying basic household expenses. This $31 must cover expenses such as clothing, telephone, and personal items, in addition to health care. Clearly, cost-sharing policies can render family coverage inaccessible for both low and moderate wage employees.

Job Transitions

As parents move from job to job, their children's eligibility for employment-based insurance is affected by several factors, including mandatory waiting periods, preexisting condition exclusions, and cost-sharing. Many employers impose a mandatory waiting period of three to six months before a new employee and his/her family is eligible to participate in the employment-based insurance program. These families, many of whom are unable to afford to continue their former health coverage through COBRA payments, are left in an "insurance gap."[22]

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which set new standards for health insurance access, portability, and renewability. Unlike many state-based insurance reform efforts, HIPAA applies to businesses who self-insure, as well as to the group and individual markets. Among other things, HIPAA limits an insurer's ability to deny or limit coverage because of a pre-existing condition. While a group health plan can exclude coverage of a pre-existing condition, in general, this exclusion is limited to a period of 12 months. In addition, cases involving pregnancy, newborns, or newly adopted children who become covered under the plan within 30 days of birth or placement for adoption are not subject to preexisting condition limits.[23]

While this law does help some families retain health coverage as they change health insurance providers, many families cannot take advantage of this protection. A recent report from the General Accounting Office states "consumers attempting to exercise their right have been hindered by carrier practices and pricing and by their own misunderstanding of this complex law."[24] There is evidence that even when coverage is offered, the cost may be prohibitive. Individual premium costs skyrocket as the insurer passes along the full cost of coverage to the family. Unless the federal legislation is revisited, preexisting conditions will likely continue to be a substantial barrier to an individual's ability to continue coverage.

Insufficient Benefits Packages

Employment-based health insurance typically carries a benefits package designed for adults. Services such as physical therapy and speech therapy generally come with a finite time limit appropriate for the rehabilitation of an adult with a temporary loss of function or injury. Young children may have need of on-going services to develop a function, and may quickly exceed the limits of a policy. Children also have greater needs for assessments of their developmental and behavioral status, since early intervention can avert many serious problems. Underinsurance is a greater problem if a family does not have significant disposable income. Such families may not have sufficient funds to pay for services that are not covered.

chapter 3

Publicly Funded Health Care

As health care costs have increased, many uninsured families have found themselves unable to afford even a basic, preventive visit to the pediatrician. A variety of publicly funded programs enable hundreds of thousands of Arizona children to access needed health care. These programs serve different populations of children, under different administrative auspices, and offer a variety of services. Most publicly funded health programs are offered to families with low and moderate incomes. Eligibility for these programs is often linked to a family's income, or " poverty status." For example, an uninsured child may be eligible for KidsCare if his or her family income is at or below 200% of the federal poverty level. Poverty level is based on the size of the family and family income. The chart below displays poverty levels for different family configurations.

Annual Income at Various Federal Poverty Levels and Family Sizes, 2000*

Family Size	100% of the FPL	150% of the FPL	175% of the FPL	200% of the FPL
2	$11,250	$16,875	$19,687	$22,500
3	$14,150	$21,225	$24,762	$28,300
4	$17,050	$25,575	$29,837	$34,100
5	$19,950	$29,925	$34,912	$39,900

*Revised annually based on inflation.

BEST COPY AVAILABLE

Public Health Insurance

In Arizona, publicly funded health insurance programs enable eligible children to enroll in a health insurance plan that provides comprehensive inpatient and outpatient services. Arizona's two main public health insurance programs for children are the Arizona Health Care Cost Containment System (AHCCCS) and KidsCare. Figure 8 shows income eligibility for AHCCCS and Arizona's other publicly funded health coverage programs.

Arizona Health Care Cost Containment System

The Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid and indigent health care program, began in 1982. This health insurance program enables low-income individuals and families to access free preventive, acute care, behavioral health, and long-term care services. AHCCCS, the first Medicaid program in the country designed to operate fully under a managed care environment, contracts with private and public managed care health plans and reimburses the Indian Health Service for the cost of services provided to Native Americans enrolled in Medicaid.

In many states, Medicaid faces difficulties in finding an adequate number of providers, due to very low reimbursement rates. The AHCCCS managed care system has overcome this major barrier by ensuring adequate compensation for services.

Population - FY98	Funding - FY98
241,449 children ages 0-18*	$2.25 billion for children and adults —$1.3 billion (59%) federal Title XIX[17] —$0.7 billion (29%) state —$0.2 billion (11%) counties/other

*These population figures do not include children participating in the MN/MI, EAC, or EUC programs.

Eligibility

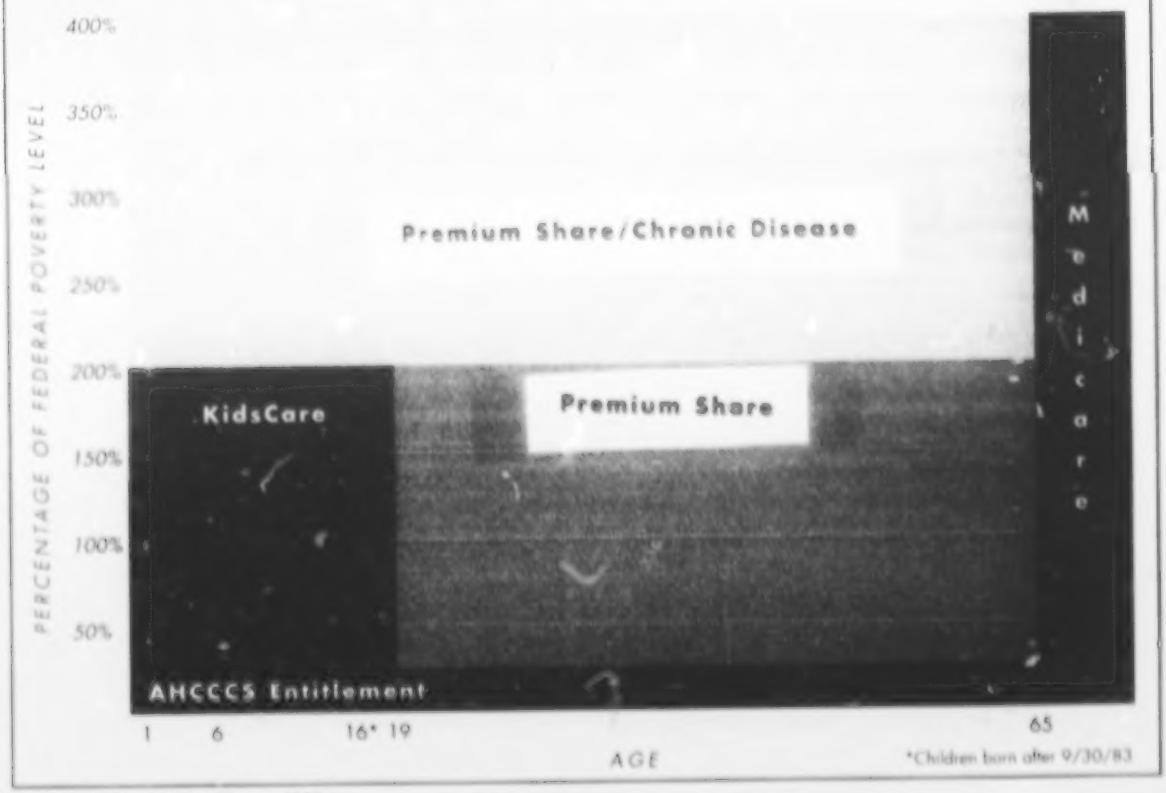
Originally, AHCCCS eligibility was limited to families who were enrolled in cash assistance programs (Aid to Families with Dependent Children—welfare, or the Supplemental Security Income program). Through the years, a strong link remained between welfare and AHCCCS. However, in the 18 years that AHCCCS has been in operation, the program has expanded to include services for pregnant mothers and infant children and other low-income uninsured people who do not qualify for welfare.

Generally, eligibility for children varies by age, income, and disability status. With the exception of pregnant women and infants, Arizona's Medicaid eligibility is set at the minimum allowed by federal guidelines. Children who are eligible for the Supplemental Security Income program because of a disability are automatically eligible for AHCCCS. In addition, income-eligible families who have health insurance that does not offer comprehensive coverage can apply for AHCCCS and receive access to services that are not covered by the primary insurance package.

Covered Services

AHCCCS covers all medically necessary services for children, including a broad range of outpatient and inpatient, preventive and acute care services. Children ages 0-21 years old enrolled in AHCCCS

FIGURE 8: **ELIGIBILITY FOR PUBLICLY FUNDED HEALTH CARE COVERAGE**



Source: Children's Action Alliance 1999

also can receive complete physical exams and immunizations (often needed to enroll in school), dental screenings and treatment, eye exams and glasses, hearing tests and hearing aids, and nutritional information. Most important, according to federal law all children enrolled in AHCCCS should receive Early Periodic Screening, Diagnosis and Treatment (EPSDT), a standard guideline for well-child care and treatment, to ensure that children are healthy and achieving appropriate developmental milestones.

Cost-Sharing

In accordance with federal law, no premiums are charged to participate in the AHCCCS program. A $1 to $3 co-payment is charged for some services.

Limitations

- Historically, AHCCCS has been linked to the receipt of welfare. This linkage has produced a number of barriers to enrollment in AHCCCS related to the welfare system. Since 1996, the linkage between these two programs has been severed. That is, a child no longer needs to be enrolled in the cash assistance program in order to receive AHCCCS. Some barriers created by

the past link, however, make it difficult for families to enroll and also influence the perception of the health coverage program.

- Specific circumstances, such as date of immigration, may render legal, permanent residents of the US ineligible for public benefits programs.

KidsCare

In May 1998, Governor Jane Dee Hull signed the Arizona Children's Health Insurance Program, also known as KidsCare, into law. This legislation enabled Arizona to develop and implement a new health insurance program that will potentially reach 65,000 uninsured children in Arizona. This comprehensive health insurance utilizes the same provider network as AHCCCS. Other managed care plans may choose to offer coverage through KidsCare, although none have done so to date. In addition, the legislation governing the KidsCare program provides an option for families to choose a package of health services, the direct services program, instead of insurance. [26]

Population - November 1, 1999	Funding - FY99
24,232 children ages 0-18	$9.5 million —75% federal —25% state

Eligibility

During the first program year, KidsCare was available to uninsured children under age 19 with family incomes at or below 150% of the FPL who were not eligible for AHCCCS and who met other program guidelines. In October 1999, the income limit was raised to 200% of the FPL. KidsCare has dramatically expanded uninsured children's access to health insurance, yet some children are ineligible due to factors other than income, including those whose parents are state employees or some categories of immigrant children who entered the U.S. after August 22, 1996. Children who have health insurance coverage through a parent's employer or who recently lost coverage can only become eligible for KidsCare after being uninsured for six months. This rule does not apply to children whose parents involuntarily lost their health coverage.

Covered Services

The kinds of services available to children enrolled in KidsCare are the same as those offered to state employees through their benefits program. KidsCare covers a variety of health care services including prevention, well-child visits, dental services, acute care, and inpatient and outpatient surgery. Covered benefits are comparable to those under AHCCCS with the exception of limitations on the number of covered days for behavioral health services and limits on vision services. In addition, unlike AHCCCS, non-emergency transportation is not provided under KidsCare.

Cost-Sharing

For children under 150% of the FPL, there are no cost-sharing requirements or parent fees other than a $5 co-payment required for non-emergency use of an emergency room. For children whose family income is between 151% and 200% of the FPL, premiums are set on a sliding-scale based on family income and the number of children in the family. A family with income between 151% of the FPL and 175% of the FPL will pay premiums of $10 a month for the first child and $15 a month for two or more children. A family with an income between 176% of the FPL and 200% of the FPL will pay $15 a month for one child and $20 each month for two or more children. Therefore, the maximum premium contribution required from a family will not exceed $240 per year.

Limitations

- The funding appropriated for KidsCare will not cover all eligible children. There are an estimated 100,000 children who are income-eligible for KidsCare, but not enrolled.[27] While not all of these children will meet the eligibility criteria, the existing federal allocation and state Tobacco Tax allocation only finances the cost of KidsCare coverage for approximately 65,000 children.
- KidsCare reaches an uninsured population that has not previously had publicly funded health coverage available. Many parents are not aware that their children are eligible. It will take a concerted and sustained effort to reach and enroll all eligible children.
- Due to federal law, children of state employees or others who are eligible for coverage under the state employees benefits package are not eligible for KidsCare. This includes counties and municipalities insuring their employees under the state employees benefits package.
- Specific circumstances, such as date of immigration, may render legal, permanent residents of the US ineligible for public benefits programs.
- Children who currently have health insurance are not eligible for KidsCare, even if the coverage is minimal.
- The benefits package, although generous, does not meet all child-specific needs. For example, vision services are limited to one set of corrective lenses and one eye exam per year. Because of rapid changes due to growth, children may need more than one visit to assess changing vision status.

Other Public Health Insurance Programs

Premium Sharing Program

The Premium Sharing Program provides health care benefits to uninsured individuals in Cochise, Maricopa, Pima, and Pinal Counties. This state Tobacco Tax-funded program provides comprehensive health insurance to families who pay a monthly premium based on income. To be eligible, family income cannot exceed 200% of the FPL. The amount of monthly premiums depends on family size and income, but does not exceed 4% of household gross income. A family with income between 200% and 400% of the FPL, who have a chronically ill member, may still be eligible for the premium sharing program. These families must pay the full cost of coverage. The Premium Sharing Program collects modest copayments on most services. To be eligible for enrollment, an applicant must have

been uninsured for the previous six months. *With the advent of KidsCare, the Premium Sharing Program serves primarily to cover adults.*

Limitations

- The program is funded entirely with state dollars through the Tobacco Tax Medically Needy Fund. By not leveraging federal health care dollars, the program is limited in the number of people it can cover.
- The level of cost-sharing required, although modest, has prevented some families from staying enrolled in the program. Over 15% of members are disenrolled each month, primarily for failure to pay an average monthly premium of $19.

DDD—Division of Developmental Disabilities

DDD provides services and supports for adults and children with developmental disabilities and for children under six years old who are likely to become developmentally disabled and who are not eligible for Medicaid. For children, these services include case management and services such as physical and occupational therapy and respite care. Care is coordinated with local school districts for education-related services. Eligibility includes Arizona residents who have a chronic disability attributable to mental retardation, cerebral palsy, epilepsy or autism, which results in functional limitations. There is a waiting list for DDD services. DDD currently serves 9,686 children under 18 years of age, and an additional 907 children aged 18 to 21 years who are receiving school-based services.

CMDP—The Comprehensive Medical and Dental Plan.

During 1999, the Comprehensive Medical and Dental Plan covered approximately 5,800 children in the foster care system with benefits equal to those available through AHCCCS. The plan, which is a fee-for-service model, covers all children in the foster care system, regardless of income eligibility for AHCCCS or KidsCare. CMDP is funded completely through state dollars for those children who are not eligible for AHCCCS or KidsCare.

SSI—Supplemental Security Income.

Children who are disabled may be eligible for health coverage through the federally funded Supplemental Security Income program. Children who are severely limited in their ability to function at an age appropriate level are eligible. The severity of a limitation is assessed by marked or extreme limitations in functional capacity. SSI benefits are designed to be flexible, so that individual families may use them to allow a child to stay at home who might otherwise need extensive care or institutionalization. A child receives SSI in addition to Medicaid benefits. Approximately 17,000 children in Arizona received SSI benefits in 1999.

ALTCS—The Arizona Long Term Care Program.

The Arizona Long Term Care program serves adults and children who are at risk for institutionalization due to their condition. It provides acute medical services, behavioral health services, home and community services, and a number of other supports to allow such persons to remain in their home setting. Approximately 6,300 children received ALTCS services in 1999.

MN/MI—Medically Needy/Medically Indigent Program.

The Medically Needy/Medically Indigent (MN/MI) program is a state- and county-funded program that serves Arizonans who do not qualify for Medicaid. AHCCCS estimates that the MN/MI program will spend $147 million in FY 1999 to provide care for both adults and children. State funding flows from the general fund.

The MN/MI program provides health insurance through AHCCCS to individuals who do not qualify for Medicaid[28], and whose income is at or below 35% of the FPL. In addition, individuals and families who incur large medical bills can "spend down" to the qualifying income level for the program. In 1998, 2,282 children were enrolled in the MN/MI program. Most of the children previously covered under this program will now be eligible for KidsCare.

Limitations

- Health services provided under the MN/MI program are funded entirely by state and county dollars. There are no federal funds for these services. Because a major entry point to the MN/MI program is through "spend down" due to costly medical bills, services for this population tend to be expensive.
- A person with catastrophic health expenditures can have no more than $5,000 in savings and $50,000 in other equity in order to qualify for assistance with health expenditures.

SES—State Emergency Services.

State Emergency Services (SES) funding is available to (1) certain legal immigrants who are not eligible for Medicaid, and (2) undocumented immigrants who are not eligible for Medicaid, and who meet income and resource criteria for the MN/MI program. This program provides fee-for-service care. SES is funded by state and county revenue. As of December 1999, no children were receiving SES services.

Public Health Services and Programs

Although not providing insurance, health services programs enable uninsured and underinsured children to access a variety of health care services. While they address a more limited set of health care needs and services than insurance, they are part of the safety net of care for people without insurance. Arizona has a variety of public health care programs including Tobacco Tax Programs, Community Health Centers, Children's Rehabilitative Services, Arizona Early Intervention Program, Indian Health Services, and others. The KidsCare Direct Services component also falls in this category of programs.

Tobacco Tax-Funded Programs

In 1994, Arizona voters approved a tax on tobacco products to be used to fund various health programs. Several programs have been supported with these dollars to enhance primary and preventive care. The Primary Care Development and Initial Operations fund (Part A) and the Primary Care Services fund (Part B) support services for uninsured low-income children and adults by paying for health care and capital improvements at 39 primary care clinics and 51 school-based clinics throughout the state. These programs do not cover specialty or emergency care. A third Tobacco Tax program, the Basic Children's Medical Services Program (Part C), previously provided uninsured and

underinsured children with inpatient care and outpatient specialty services. This program lost funding at the end of FY 1999.

Population - FY98	Funding - FY98
25,129 children	$17.6 million
ages 0-18	in state funding
—10,560 Part A	—$5.9 million Part A*
—13,069 Part B	—$6.7 million Part B*
—1,500 Part C	—$5.0 million Part C

*includes funding for both children and adults

Eligibility

These services are available to Arizona residents who are uninsured and do not qualify for Medicaid, KidsCare, or Medicare. Household income must fall below 200% of the FPL.

Covered Services

Tobacco Tax Parts A and B fund primary care and preventive services including well child visits and immunizations. However, each local service unit defines the kinds of services available to children. For example, a community health center may use tobacco tax funds to help low-income children get dental services, while a school clinic may offer only check-ups. These funds cannot be used for emergency care.

Cost-Sharing

The Department of Health Services, which administers the Tobacco Tax Parts A and B, does not impose a cost-sharing requirement for programs. However, the community settings that receive and use these funds often charge fees for services on a sliding scale.

Limitations

- Services supported by Tobacco Tax funds are limited by funding allocations at each site. Therefore, sites may refuse care if the available funds have already been spent.
- These programs provide primary care services only. There is no access to specialty services if a problem is identified. The Tobacco Tax Part C program, which allowed specialty care and hospitalization services to uninsured and underinsured children, lost funding in June of 1999 due to the misperception that all of these children would become eligible for KidsCare.

Community Health Centers

Community Health Centers provide a wide array of health services. Drawing on a mixture of public and private insurance, federal, state and local government grants, and patient fees for funding, Community Health Centers are able to provide health care services to uninsured patients, as well as make referrals for both physical and mental health care not provided at the clinic sites. There are 27 Community Health Centers with 72 sites operating in communities across the state.

Population - FY98	Funding - FY98
75,197 children under age 19. This includes both insured and uninsured children	$54.2 million in services and administration (includes both children and adults)

Eligibility

Community Health Centers (CHCs) are open to all Arizonans. In 1998, 38% of CHC clients were uninsured, and 32% were insured through Medicaid.

Covered Services

Services offered to clients vary depending on the health center, but may include primary care and preventive services, diagnostic laboratory and x-ray services, preventive dental, therapeutic services, vision screening and services, emergency medical, immunizations, health education, mental health counseling, and nutritional counseling.

Cost-sharing

Because Community Health Centers offer services to both privately and publicly insured clients, as well as to the uninsured, cost-sharing varies depending on insurance status and family income. For low-income clients not enrolled in AHCCCS or KidsCare, some clinics charge fees based on income. For example, a family with an annual income at or below 100% of the FPL may be charged 25% of the cost of the service. Rules about cost-sharing vary by clinic site.

Limitations

- Community Health Centers are not available in all parts of the state. Five counties do not have primary or satellite CHCs within their boundaries.[29] In some other counties, families must travel long distances to access a CHC.
- The available services vary by site. While the large CHCs often have optometry services, pharmacies, radiology, and laboratory services available on site, smaller centers do not have the same level of sophistication. In addition, specialty care may not be readily available to uninsured CHC clients.
- CHCs are service delivery sites, and do not serve the same function as insurance. Specialty care, emergency care, and hospitalization are not covered services.
- Federal appropriations for Community Health Centers are vulnerable to cuts or limitations and do not automatically rise with increasing need. Recent federal limits on payments are eroding Medicaid reimbursement at a time when CHCs are also taking on a rapidly growing population of uninsured patients.

Children's Rehabilitative Services

Children's Rehabilitative Services (CRS) provides medical treatment, rehabilitation, and related support services to medically and financially qualified children who have certain medical, disabling, or

potentially disabling conditions. They receive treatment for their specialty condition to improve overall health and functionality.

Children can be tested and receive ongoing treatment at four CRS regional, multi-specialty centers and 22 condition-specific outreach clinics throughout the state. While the four multi-specialty centers are in urban areas, the outreach clinics are located in various rural locations.

Population - FY98	Funding - FY98
15,349 children ages 0-21	$29.7 million —18% state only funds —28% state AHCCCS funds —53% federal AHCCCS funds

Eligibility

To be eligible for CRS services, the child must be under age 21, have an eligible physical disability, chronic illness, or a condition that is potentially disabling. Medical conditions that are accepted for care include birth defects (such as spina bifida, club feet, dislocated hip, cleft palate), muscle and nerve disorders, some conditions of epilepsy, cerebral palsy, cystic fibrosis, metabolic disorders (such as PKU), and others.

Covered Services

CRS provides a wide array of services related to the treatment and rehabilitation of the child's special need, including surgery, ongoing therapy, x-rays, and medications. CRS staff works with primary care physicians to coordinate care and helps parents negotiate complex medical treatment schedules.

Cost-Sharing

Cost-sharing varies depending on insurance status and income level. Families who are enrolled in AHCCCS and KidsCare have no cost-sharing requirements beyond the $3 co-payment for non-emergency use of the emergency room. Families with income at or below 200% of the FPL who either lack insurance or have private insurance do not incur costs beyond the copayment. Families with income above 200% of the FPL must pay a minimum of 100% of the rate that AHCCCS pays for a given service, if the service is not covered by insurance.

Limitations

- Although many chronic health conditions are covered under CRS, others are not. Severe asthma and diabetes are examples of chronic health conditions not covered through CRS.
- CRS has many travelling clinics. However, as with most health care in the state, services are concentrated in the four largest population centers. Children from rural areas may need to travel long distances for some specialized services.
- There is a risk for lack of coordination of care between the CRS specialists and the primary care physicians. A child with special health care needs must also see primary care doctors, in an entirely different coverage system, to get regular preventive care. When the communication

between the specialists and primary care physicians does not occur in a timely manner, the primary doctor may be unfamiliar with the child's special need or current care regimen.

Arizona Early Intervention Program for Infants and Toddlers

The Arizona Early Intervention Program for Infants and Toddlers (AzEIP), administered by the Department of Health Services, identifies infants and toddlers who have developmental delays, provides screening and evaluation services, and helps families find and coordinate services.

Population - FY98	Funding - FY98
1,601 children ages 0-2	$5.2 million (This figure includes legislatively appropriated state funds, AHCCCS, Title V Maternal and Child Health Block Grant, and Part C of Federal IDEA funds.)

Eligibility

Children ages birth to three who have developmental delays or established conditions known to be associated with developmental delays are eligible for services. For example, any child who is functioning at 50% or below average in physical, cognitive, language, social or emotional development is eligible for AzEIP services.

Covered Services

AzEIP provides screening for eligibility, case management, and referral to appropriate health care providers. In addition, AzEIP helps families navigate the system by coordinating providers in the system.

Cost-sharing

AzEIP services are free to participating families.

Limitations

- Lack of available services. While there is no waiting list for AzEIP screening and case management services, the agencies to which children are referred may have no open slots. There are geographic differences in the availability of services coordinated by the AzEIP program. Services such as audiology, vision screening, and treatment of speech and language disorders may not be readily available in all areas of the state. Although comprehensive services may be available in urban centers, specialty services are more limited in rural counties.

Indian Health System/Tribal Health Care

The Indian Health System includes three categories of providers funded through the Indian Health Service (IHS), an agency of the U.S. Public Health Service, Department of Health and Human Services, described as the I/T/U system: IHS hospitals and clinics (I); tribally contracted and operat-

ed health programs (T); and health care purchased from urban Indian programs (U). The IHS focuses on primary and preventive health care; specialty care and hospital services may be provided through contracts with other non-IHS providers.

Ambulatory Visits to Indian Health Services* - FY95	**Funding - FY2000**
—85,573 Tucson Region —642,419 Phoenix Region —917,333 Navajo Region	—$181 million Phoenix Region

*Includes both adults and children. IHS regions extend beyond Arizona's borders.

Eligibility

Enrolled members of federally recognized Indian tribes and their descendants are eligible for services provided by Indian Health Services. Tribal enrollment criteria are determined by individual tribes, but two common criteria exist: direct descendent from someone named on the tribe's original list of members, or relationship to a tribal member who descended from someone named on the base roll. Other common criteria include tribal blood quantum, tribal residency, or continued contact with the tribe.

Covered Services

Because IHS is a comprehensive service delivery system, a broad range of inpatient, outpatient, prevention and acute care, and regular and specialty care is covered.

Cost-Sharing

Cost-sharing is prohibited by federal treaty agreement.

Limitations

- Although the Indian Health system has a broad and comprehensive mission, it has been underfunded for the past several years. The IHS is an appropriated program rather than an entitlement, and funding has not reflected increases in the population.
- Because of the focus on primary and preventive care, specialty care may not be widely available. In fact, a national study of the IHS in 1996 showed that 58% of specialty care needs went unmet.
- Coordination with AHCCCS and KidsCare continues to be an active issue for the I/T/U system. The I/T/U system has had historical relations with the federal government, with less emphasis on state governments. The financial relationship between the I/T/U system and Medicaid managed care continues to evolve. A recent decision on providing payment to IHS for managed care enrollees receiving care from the IHS while on the reservation may help to improve coordination between the systems.

Behavioral Health Services

Publicly funded behavioral health services in Arizona are funded through a variety of sources and are delivered through the Regional Behavioral Health Authorities (RBHAs). There are five Regional

Behavioral Health Authorities, four nonprofit and one for-profit organization, that use public funds to provide a network of behavioral heath services for income-eligible clients. The RBHAs act as a network coordinator processing applications for services, handling some screening and treatment, and referring families to mental health services in the community. Both insured and uninsured families can use RBHA services.

AHCCCS contracts with the Department of Health Services, who in turn subcontracts with the RHBAs on a capitation basis to provide behavioral health services to Medicaid clients and for children enrolled in the KidsCare program. In addition, behavioral health services are available to income-eligible non-Title XIX non-KidsCare clients on a sliding fee scale to the extent funding is available.

Population - FY98		**Funding - FY98 (children's services)**	
27,567	Total	$83.3 million	Total
—21,387	Title XIX children	—$21.4 million	State Title XIX
—6,180	Non-Title XIX children	—$19.0 million	State Non-Title XIX
		—$40.3 million	Federal Title XIX
		—$2.5 million	Non-Title XIX

Eligibility

In order to receive services a child can either be self-referred or referred to services by a variety of agencies and health care providers. RHBAs and their contractors provide screening and evaluation services to determine necessary treatment. However, because RBHA services are limited, priority is given to AHCCCS-eligible or KidsCare-eligible clients, adults who have serious mental illness, and pregnant women who have alcohol or other drug problems. In addition, non-Title XIX children and families may be eligible for subsidized services based on income eligibility.

Covered Services

The RHBAs are responsible for providing the full range of behavioral health services. This includes screening and evaluation, general mental health services, behavioral therapy, life skills, parent and family education, crisis services, treatment of serious emotional or mental illness, and substance abuse services.

Cost-Sharing

For children participating in AHCCCS, there is no cost-sharing for mental health services covered by AHCCCS. However, co-payments may be assessed for services not covered by AHCCCS. Families who are low-to-moderate income, and have insurance that does not cover mental health services, pay for visits on a sliding fee scale based on income, number of persons in the household and cost of the service. For example, a family of four with an income of $1,970 a month is required to pay 10% of the full-cost of mental health services provided by the RHBA. Families with children with an

Individualized Educational Plan that requires residential care are requested, but not required, to make a contribution according to this co-payment schedule.

Limitations

- The system is not funded adequately. The RHBA system is mandated to provide all necessary services to AHCCCS and KidsCare clients within the limits of the benefits package. However, because of limited state funding for non-Title XIX, non-KidsCare clients, these clients may be under-treated or discouraged from using services.[30,31]
- The primary health care system and the behavioral health care system are not well coordinated. This leads to a lack of communication and poses risks for delays in obtaining service.

Other Health Services Programs

County Health Services

County health departments often offer a variety of health services to low-income families. These services may include free or low-cost immunizations; screening and treatment for tuberculosis, sexually transmitted diseases, and HIV; and food maintenance programs such as WIC.[32] For example, Pima County is expecting to spend $1.5 million in FY2000 on health care services for youth including well-baby check-ups, immunizations, disease control, family planning and a teen health center.[33] The types of services available in different counties vary widely.

In addition to outpatient health services, both Maricopa and Pima Counties support county hospitals, providing care for the indigent. Arizona counties paid an estimated $29 million in FY98 to hospitals for the care of indigent patients (both children and adults). These services are subsidized, in part, by the federal government through the Disproportionate Share Hospital grants.

Limitations

- The funding and services available through county health departments address specific health care needs, but cannot address the overall health care needs of the client.

Uncompensated Care

A variety of locations — both public and private — treat uninsured children at no or minimal cost to the family. For example, some pediatricians agree to treat a number of uninsured children without compensation. In addition to Community Health Centers, discussed above, hospital clinics and emergency departments provide health care for which they are not paid. Emergency departments are prohibited by law from turning patients with emergency medical conditions away or from diverting them to other hospitals.[34]

Limitations

- The availability of non-emergency uncompensated, or "charity" care is based on the ability of a hospital or physician's office to offset the costs of this care through other revenues. As managed care, with its emphasis on cost-savings, becomes the rule rather than the exception in health insurance, the ability of hospitals and physicians to shift costs to cover the cost of uncompensated care is greatly diminished. In addition, it is difficult to ensure that a treatment plan can be completed through a charity care setting.

- Prescription medications or laboratory tests may not be available in a charity care setting and may be unaffordable to an uninsured person.
- The Balanced Budget Act of 1997 included cuts to federal disproportionate share hospital payments. These cuts are likely to significantly limit the ability of hospitals to provide uncompensated care.

Health Care Linked through Schools

Arizona's efforts to link schools with children's health care have been successful in two arenas: the Medical Home Project and School-Based/School-Linked Services. Both are designed to increase children's access to primary care.

The American Academy of Pediatrics-Arizona Chapter administers the Medical Home Project, a system of linkages between school nurses and medical providers statewide, to provide acute and episodic medical care for uninsured children from low-income families. The volunteer medical providers donate appointment slots to see children in their offices and agree to accept $5 to $10 as payment-in-full for each visit. The Medical Home Project is particularly beneficial to sick children who may be eligible for private or public insurance, but because of waiting periods and administrative delays, have not been cleared to see a medical professional. Over 1,100 child-visits occurred with physicians, dentists, and optometrists through the Medical Home Project during the 1998-99 school year.

There is a growing network of school-based or school-linked health care centers helping children access primary care across Arizona. These centers are generally established in areas where the medical needs of the students are not met outside the school. Depending on the center, school-based and school-linked services include primary and preventive care, including treatment of students who come to school ill. There are over 180 school-based/school-linked health centers in Arizona.

Limitations

- The Medical Home Project has similar limitations to that of uncompensated care. A child may have a serious or chronic health condition identified, but the Medical Home Project does not have resources for extensive diagnostic tests or on-going treatment of chronic conditions.
- School-based health services may be limited in hours the offices are open.
- There are strong philosophical differences about the appropriateness of providing health care within the schools. This makes on-going support for these programs uncertain.
- Funding for school-based health services is tenuous. Most school-based clinics are funded through a combination of grants and partnerships with hospitals or businesses. Without a fixed income source, school-based clinics must continually seek out new sources of funding.

chapter 4

Gaps in the Health Care System for Children

Even with the variety of health insurance and direct service programs for children described above, many children remain ineligible, and significant holes in the "safety net" exist. In mid-1999, Children's Action Alliance interviewed 12 Arizona experts to gather opinions about the health care system and garner a better understanding of the problems that exist with health coverage — both public and private — for children. The following is a summary of the system, population, and service gaps identified in these discussions. While this summary may not include all of the gaps in the current private and public systems of health care for children, it does provide an overview of the most significant gaps.

System Gaps

Much of Arizona's health care system is not a system at all. Different components have been developed in response to emerging needs. Programs created to respond to specific health conditions or to specific population needs create a patchwork quilt of health services. The specific eligibility and services rules of various funding streams make it difficult to coordinate care and leave some children out. The complex structure of the health system makes it difficult for families to access care.

In addition to the difficulty accessing care, fundamental holes exist in the health care system. Gaps in the system include:

- **Decline in Accessible Employment-Based Coverage.** The changing job market, with increased emphasis on part-time work, out-sourcing, and consulting jobs, has resulted in fewer employees being offered health coverage through large employers. Small businesses and service-oriented businesses historically have had low rates of employment-based health coverage.

- **Cost-sharing.** Cost-sharing has an impact on both private and public coverage. Most families can afford some level of cost-sharing, but affordability depends on family income. Cost-sharing as low as 1% of family income has been shown to preclude some families from accessing needed services.

- **Limited Funding.** Although there are several public health care programs to help uninsured children access either insurance or health care programs, funding limitations mean that not all eligible children can participate. For example, funding for KidsCare is capped, effectively restricting enrollment to 65,000 of the over 100,000 children who are potentially eligible. Similarly, Indian Health Services funding is so limited that there are significant waiting periods to receive basic services in many parts of the state.

- **Administrative Barriers to Enrollment.** According to research by the American Academy of Pediatrics, approximately 152,000 uninsured children in Arizona are eligible for AHCCCS but not enrolled. In a June 1999 report, *Children Without Health Insurance: Listening to Arizona's Parents*, Children's Action Alliance identified issues including onerous paperwork requirements and application procedures as barriers to enrolling in AHCCCS. While many of the barriers that have been a problem with AHCCCS have been retooled for the KidsCare program, some parents are still having difficulty successfully completing the application. Removing these administrative barriers can succeed in expanding health coverage, but will, at the same time, increase program costs for state agencies.

- **Lack of Access to Immediate Care.** Most children who are applying for public or private health insurance coverage are unable to get services right away. For example, if a child has an ear infection and applies for KidsCare to get health insurance, he cannot be enrolled in time for the needed visit to the doctor to be covered. Employment-based insurance is generally not available for three to six months after initial employment. These gaps in coverage can result in delayed care.

- **Regional Scarcity of Medical Professionals.** Arizona faces unique challenges in assuring adequate medical care to many of its citizens living outside the urban centers. In addition, residence in an urban area does not guarantee access to medical care. There are some parts of Arizona that lack basic medical staff. Sixty-four areas in the state, serving 13% of Arizonans, are designated as Health Professional Shortage Areas, including both rural and urban sites.[37] Five of the fifteen counties in Arizona lack Community Health Centers. There are no pediatricians available in Apache, Greenlee and Graham counties. Children in these counties see family practitioners or general practitioners. Pediatric specialists are available only through the Children's Rehabilitative Services system in most communities outside the Phoenix or Tucson areas. Even if a child is insured, there may be no health care providers in their community or very long waiting lists to see the providers in the community. This is a particular problem for specialty care, because pediatric specialists are rare outside of the urban areas.

  Some efforts have been made to attract providers to such underserved areas. These programs include loan repayment/forgiveness programs and medical school rotations in rural communities to expose young doctors to the realities of practice in such communities. Such programs have been met with success at drawing physicians to rural practice.

- **Native American Health Care.** The Indian Health System is underfunded and suffers from the same lack of medical professionals as many other rural communities. Because the Indian Health System is funded through a federal appropriation, funding is subject to broad federal spending caps. The IHS can supplement funding by enrolling clients in AHCCCS or KidsCare, but tribal members may be reluctant to enroll. Tribal members can be enrolled in KidsCare or AHCCCS and still see IHS providers for their care.[36] In addition, the federal government pays 100% of the cost for many Medicaid services provided to tribal members enrolled in AHCCCS and KidsCare, and delivered at an IHS facility.

  Urban Indian health care facilities do not see the same financial benefit from increased AHCCCS and KidsCare enrollment as does the IHS. The urban Indian health care facilities do not receive the 100% federal matching rate as does the IHS. Urban facilities must enroll as providers in the managed care network, and thus feel the same cost pressures resulting from tight revenues and inability to cost-shift as do other clinics serving a primarily Medicaid clientele. Urban Indians also do not have access to tribal contract health services funds for specialty care. As a result, urban facilities are faced with the need to serve a culturally distinct population with extraordinarily tight budgets.

  In order to access the full benefits of health insurance, qualifying urban Indians may enroll in AHCCCS or KidsCare. However, non-IHS urban Indian health care facilities may not be providers within the managed care network, and are therefore unable to serve this population.

Population Gaps

While an increasing number of children are eligible for insurance programs and health services, some children are being left out of programs, either because of program design or implementation. Lack of health insurance disproportionately affects minority and foreign-born populations and the near-poor. Population gaps include:

- **Children Whose Parents Leave Welfare.** In most cases, adults leaving welfare for work do not have access to employment-based health coverage. And in most cases, parents are not aware both they and their children remain eligible for AHCCCS or KidsCare for two years or more, so they do not re-enroll. As a result, the number of children enrolled in AHCCCS dropped markedly in 1997 and 1998 as time-limited welfare benefits were implemented. Approximately half of adults leaving welfare in the past two years also lost Medicaid coverage. Often, their children lost Medicaid as well. Only now, with the advent of outreach for KidsCare and simplified enrollment procedures, are children reappearing on the AHCCCS rolls. This population leaving welfare contributed to the large number of children who are AHCCCS-eligible, but not enrolled.

- **Uninsured Children Who Cannot Qualify for Coverage.** There are several populations of children who are categorically ineligible for public health insurance and services. For example, some immigrant children and children of state employees are not eligible for KidsCare. Further, there are about 60,000 children in Arizona whose income exceeds 200% of the FPL but who have no health insurance. Uninsured children in these categories have little or no access to safety net programs such as behavioral health services, or services for children with special health needs.

- **Children with Special Health Care Needs.** Children with very serious problems may not be covered adequately by employment-based health insurance packages. In addition, when parents with a special needs child move from one employment-based plan to another, their children, because of their serious pre-existing condition, may not be covered. While the passage of the Health Insurance Portability and Accountability Act (HIPAA) has helped some children retain coverage, there is evidence that even when coverage is offered, the cost may be prohibitive.
  In addition, families of children with special health care needs often incur substantial costs that are not covered by many health insurance policies. Such costs include durable and non-durable medical equipment, nutritional products, long-term therapies, and the costs of travel to obtain care. These costs, which can impose significant out-of-pocket costs on a family, may stand in the way of a child receiving necessary care.

- **Migrant, Homeless, and Runaway Children** are among Arizona's most vulnerable and the least likely to be able to access regular health care. Children living in migrant families often have great difficulty obtaining health services for several reasons. First there are a lack of providers serving migrant and rural communities. In addition, managed care systems, such as AHCCCS or KidsCare, are based on geographically specific provider networks. Kids who move frequently have difficulty using these systems. Homeless and runaway children are very difficult populations to reach and often go without regular health care. Statewide, at any point in time, an estimated 3,000 children are homeless. In the course of a year, a total of 8-10,000 children are estimated to be homeless.[37] These children most often seek medical care in emergency rooms.[38]

- **Teens.** Teens are a group of children at great risk of not receiving needed care for several reasons. First, many teens have not had access to public health insurance. Income eligibility for AHCCCS, at 100% of the FPL, has only recently expanded to include teens up to 16 years old, compared to 32% FPL for older teens and adults. Secondly, teens may be in need of services not easily available to them such as confidential discussions about sexuality. Physicians, in general, are not specifically trained in treating adolescents, and may not feel comfortable caring for teens, with their complex range of physical, social and behavioral health issues. Third, health care programs, both public and private, may not pay for some recommended preventive services such as immunizations. Finally, teens are the most likely of all immigrant children to lack citizenship and associated access to publicly funded health care.

- **Minorities.** Minorities are disproportionately represented in the uninsured population. Several factors influence this, including higher rates of poverty among minorities. Working minority families, particularly Hispanic workers, have less access to employment based insurance than white workers in the same employment situations. This relationship exists across salary levels, company size, and occupations.[39]

  Native Americans also are disproportionately uninsured. The Indian Health System, which provides health services to American Indians, is not health insurance. American Indians receiving services through the IHS may not have access to some necessary services.

- **Immigrant families.** The difficulties facing immigrant families are multifaceted. Most immigrant families are mixed-status families, families containing both citizen and non-citizen members.

Because of this, both citizen children and children with lawful permanent residency (LPR) status face barriers in accessing health insurance.

Until the 1996 welfare reform law (The Personal Responsibility and Work Opportunity Reconciliation Act or PRWORA), income-eligible legal immigrants and their families could obtain publicly funded health coverage, and other public benefits. Since the Welfare Reform Act was signed into law, however, access to benefits has been restricted. For most categories of immigrants, persons entering the U.S. after August 22, 1996 must wait five years before they can receive any public benefits. Immigrant children, in general, are much less likely than US-born children to have health insurance. National data show 34.1% of foreign born persons lack health insurance compared with 14.4% of people born in the U.S. This is exaggerated among the poor, with 53.3% of foreign-born poor persons lacking health insurance, compared with 29% of people born in the U.S.[87]

In addition to the gap in eligibility, there is a less tangible gap for children in immigrant families: that of "public charge." Public charge is a term in immigration law that has existed for over a century, but which has recently been brought into sharp focus by the Welfare Reform Act. Assessing an immigrant's risk of becoming a public charge involves a review of age, health, family status, financial status, and education and skills. The assessment occurs at the time an immigrant applies for admission to the U.S. or to adjust status to become a lawful permanent resident. Prior to May 23, 1999, there was no clear definition about whether the use of specific public benefits would adversely affect an immigrant's request for LPR status.

In May 1999, the US Immigration and Naturalization Service released a new regulation defining public charge. Use of health benefits, other than institutionalization for long-term care, by eligible family members, will not adversely affect an immigrant's ability to attain LPR status, or to sponsor other immigrants' application for LPR status.

Although this policy has recently been clarified, the impact on reducing the number of uninsured children has yet to be determined.

- **Undocumented immigrants.** Arizona is home to a growing population of undocumented immigrants. Such immigrants are unlikely to receive employment-based insurance and are not eligible for a variety of publicly funded programs. There are clear political and ethical forces that influence the decision not to provide health care to this population. It is important to recognize, however, the need to provide a basic level of services in order to protect the health of the general public. Recent outbreaks of measles and rubella have been linked to unimmunized immigrants fearful of accessing the health care system. Tuberculosis, a contagious airborne infection, may go undiagnosed or untreated because of lack of access to care.

Service/Coverage Gaps

Most health insurance programs offered to children cover a wide range of services. However, many health benefits packages offered to children are actually tailored to the adult population. Children are not small adults and have differing health needs. Children are developing, growing, and undergoing physical and emotional changes at rapid rates. Where an adult might need a short-term treatment to return to his or her usual state of health, a child may need long-term treatment to establish

that state of health. For example, most health insurance covers vision services, including one set of corrective lenses and one eye exam each year. A young child, in whom brain pathways for eyesight are still being established, could have significant changes in vision over the course of the year. If that child cannot have several changes to corrective lenses, the child's eyesight may be permanently affected.

Problematic service gaps include:

- **Dental Health.** Dental caries ranks as one of the top health problems faced by children today. There are significant differences in the occurrence and severity of caries and of access to dental care for children across the state. There are 13 Dental Health Professional Shortage Areas in Arizona.[31] In addition, some employment-based benefits packages do not include dental coverage as a standard benefit.

- **Behavioral Health.** Many children, even very young children, require behavioral and mental health care. Unfortunately, behavioral health is often not sufficiently covered in private health insurance packages. In addition, behavioral health is not sufficiently covered in the KidsCare benefit package or the state employee health insurance plan. With declining financial support for non-Title XIX, non-KidsCare services, many near-poor children will lose access to behavioral health services. In addition, families earning over 200% of the Federal Poverty Level who are not eligible for state-funded care may be faced with extraordinary medical bills for the care of a mentally ill child who has exceeded the private insurance benefit.

- **Children with Special Health Care Needs.** Children with special health care needs require specialty services to remain healthy and improve functionality. Most employment-based systems fall short on specialty care for children and have little access to specialty care medical professionals. However, children with chronic health conditions are more likely than adults to have rare conditions. Children in the public system end up having much better access to qualified specialists than children in private health insurance plans. However, even the public health care system for children with special health care needs has emerging gaps in coverage. For example, a number of conditions that were once covered by Children's Rehabilitative Services funding, including chronic asthma and juvenile diabetes, are now no longer covered. Children with these serious, and sometimes life threatening, problems may have little access to specialized care.

- **Underinsurance.** Insurance plans differ in the types of services covered. In many cases, prescription drug coverage, vision, hearing and dental care are not covered services. This can directly affect health status. For example, asthma is one of the leading chronic health problems for children. Even when provider visits for asthma are covered, if prescription drugs are not covered, the medication can be too expensive for parents to purchase, and the child then suffers from unaddressed breathing problems.

Recommendations

Given the goal of maximizing the number of children with health coverage from any source, it is important to develop a multi-faceted solution, building on the strengths of the existing system. It is also important to recognize that employment-based family health coverage is unlikely to be the solu-

tion to expand children's health coverage. In the face of our booming economy and record low unemployment levels, the number of uninsured children (and adults) has soared. Economic pressures have constrained the ability of employers and families to cover the full costs of coverage.

Therefore, our recommendations focus on strengthening the publicly funded health care system, augmenting the current safety net, and supplementing employment-based coverage.

- **Work to fully enroll eligible children in AHCCCS and KidsCare.**

  Arizona currently has an estimated 370,000 uninsured children. Of these children, approximately 280,000, or 80% of uninsured children, are income eligible for AHCCCS or KidsCare, but are not enrolled. Past experience with Medicaid expansions shows that it takes several years before knowledge about newly available coverage filters to the eligible population and enrollment numbers increase.

  It will take a sustained and concerted marketing effort to ensure that all eligible families are informed about the availability of these programs. Working families whose children have never before been eligible for publicly funded health insurance may not be aware their children are eligible for KidsCare or AHCCCS.

  Some families and legislators may perceive such health insurance as a "welfare" program. It is interesting that no such stigma is attached to Medicare, a similar publicly funded health insurance program created in recognition of a population who had difficulty obtaining employment-based coverage. Working families are taxpayers who pay to support these health coverage programs in the same way they do Medicare.

  If we are to be successful at enrolling all eligible children in AHCCCS and KidsCare, the enrollment process will need to be improved. KidsCare has not only opened the door for many more uninsured children to become insured, but has provided major impetus for changing the enrollment process. In addition, the de-linking of Medicaid and welfare provides another significant opportunity to simplify the application process. We must continue to make this application process as user-friendly as possible in order to help working parents.

- **Offer premium subsidies to families.** Further options for employment based insurance for children must be made available. A major factor in the debate about publicly funded health insurance is the premise that workers and their dependents receive, or should receive, health coverage as a benefit of employment. Many employers do provide heavily subsidized health coverage for the employee, but are not able to afford to subsidize family coverage to the same extent. Other employees may not be eligible for coverage. We lack Arizona-specific data about the offer and take-up rates of employer-sponsored health coverage, but there is evidence that many low and moderate income families cannot afford the premiums required for family coverage.

  Such families could benefit from state support of the employee cost of insurance to broaden the private sector insurance base. One example: Arizona state employees must pay $900 per year to enroll in the lowest cost family coverage program. Due to federal rules, these employees are not eligible for the KidsCare program. KidsCare eligibility staff, who earn less than $20,000 per year, often cannot afford to insure their own children. By subsidizing the employee's contribution, the state could work with a public/private partnership to expand access to insurance. In addition,

assisting families with premium subsidies will reduce the likelihood of "crowd-out" or the potential loss of employment-based coverage when publicly funded programs become available.

- **Maximize state health dollars by leveraging federal monies to fund health coverage.**
Arizona has not taken full advantage of federal dollars available to expand health coverage. For example, the Premium Sharing Program, funded solely by state dollars, offers an opportunity for thousands of people without other access to health insurance to purchase an excellent benefits package on a sliding fee scale. This program addresses a significant population gap in Arizona. However, it relies solely on state revenues for funding. By leveraging federal dollars through the Medicaid program, the state could fund a higher level of coverage for adults and/or children. The state could draw down federal dollars either through an amendment to our existing 1115 Waiver, or by using a 1931 waiver, which allows parents of children eligible for Medicaid to enroll in Medicaid at a 65%: 35% federal subsidy. This would allow state funds earmarked for the Premium Sharing Program, or similar programs, to reach more people.

- **Develop and promote health insurance purchasing pools for small businesses, or enable individuals or businesses to purchase health insurance through AHCCCS or through the state employee health plans.**
A major factor that allows individuals or small employers to purchase a reasonably priced, quality health benefits package is the ability to enter a large "risk pool." Such risk pools spread the costs of covering older or sicker individuals over a greater healthy population.

  For the past 13 years, Arizona has had such a purchasing pool. The Health Care Group, managed by AHCCCS, provides an opportunity for Arizona small businesses to purchase group health insurance. However, it has had start-up difficulties and had become a last-payor for high-risk employees. Legislation enacted in 1999 should help to alleviate that problem by requiring an employer to enroll all employees, not just the sickest. If this approach is successful at stabilizing the financial status of the Health Care Group, the program could be marketed better to small employers, or perhaps, merged with the Premium Sharing Program to offer sliding scale coverage through small employers as well as to individuals. In addition, allowing Arizona residents to purchase full-cost individual coverage through the AHCCCS risk-pool or the state employees' health plan would make such individual coverage available with lower deductibles, better benefits, in a more cost-accessible manner than trying to purchase coverage on the individual market. (It is important to note that if an individual or employer purchases health coverage through the state employees benefits plan, children within the family would no longer be eligible for KidsCare.)

- **Increase funding for CHCs and other safety net providers, expand the network.**
One common argument against expanding health insurance coverage is that people can always find care when they need it. This is not based in fact. Recent legislation in Arizona has both helped and hurt the safety net. Major enhancements to the safety net include the Tobacco Tax Part A and B programs. Legislation that has harmed the safety net includes the de-funding of Tobacco Tax Part C, which funded specialty care and hospitalization for uninsured and underinsured children who are not eligible for KidsCare and cuts to funding for the Behavioral Health System and Children's Rehabilitative Services. All these budget cuts were based on the assumption that children previously covered by state funding would be able to enroll in KidsCare. However, as

addressed above, there are categories of children who are not eligible for KidsCare, including children of state employees who cannot afford the monthly premium contribution.

Community Health Centers and other safety net providers are a critical part of the safety net, providing care to many segments of the uninsured population. Recently, these clinics and hospitals have been facing increasing financial pressures through cost cutting in the Medicare program and through the increasing pressures of managed care. In addition, in Arizona, the network doesn't extend to many geographic areas in need of such facilities. There is a need for funding for more clinics in underserved rural areas, and continued subsidies for the costs of providing care to individuals who cannot or will not enroll in public or private health insurance.

As managed care market penetration grows, fewer private physicians and public clinics will be able to cost shift to support uncompensated care. In addition, even when primary care can be offered, a need for specialty care, laboratory services and prescription coverage continues to exist. The assumption that people can always receive treatment if needed is incorrect, and policy should be created with this in mind. Barring a sweeping increase in the rate of Arizonans with health insurance, Arizona needs to increase funding for health care services.

- **Develop a recommended child-friendly benefits package.**

Because children, in general, are healthy, they are one of the least expensive groups to insure. However, health benefits packages generally reflect the needs of adults rather than children. Children are less likely to require multiple medications or hospitalizations but have greater need for preventive treatments and developmental and behavioral assessments or therapies. Benefits packages offered through public and private insurers should reflect these differences in the health needs of children.

- **Align eligibility for programs**

Families who wish to enroll in publicly funded health coverage are met by a confusing array of programs with differing eligibility rules. For example, a family with two children ages 4 and 7 with an annual income of $20,000 that wishes to obtain health coverage will have to apply to, and meet requirements for, three different programs: AHCCCS (4 year-old), KidsCare (7 year-old), and the Premium Sharing Program (adults). Although efforts are underway to make the application process itself more user-friendly, each program has a different timetable for re-application, and different benefits. If the parents then wish to use other family support programs such as free or reduced school lunch, or child care subsidies, there will be other income and eligibility rules to negotiate.

To the extent allowable under federal law, we should align eligibility criteria and benefits packages such that when a family applies for health coverage, all family members receive the same benefits and meet the same timetable for re-application.

- **Support and evaluate the telemedicine program.**

Telemedicine allows access to specialty care from remote portions of the state. Arizona has a telemedicine program that is in its infancy. Although it faces many challenges, such as issues of billing, liability, interstate commerce, it also promises improved access to health care for residents

of rural and frontier communities in the state. This program should continue to be supported through its development and evaluated for ongoing usefulness.

- **Increase health education.** A critical competent to ensuring that children enroll in available programs, see medical professionals, and remain healthy is health education. Many parents are unaware of the kinds of benefits they are eligible for, their rights under public health programs, as well as proper ways to use public heath systems. In addition, there is a need to help parents better understand the need for preventive care and regular checkups for children.

  Information about the importance of health insurance must be made available through both printed and broadcast material. This can be accomplished directly through print materials, and indirectly through marketing health coverage as a desired commodity. Given the clear relationship between health insurance, improved access to health care, and improved health status, every effort must be made to ensure access to health coverage for all Arizonans.

Endnotes

1 Annual Supplement, *Current Population Survey*, U.S. Census Bureau, March 1999.

2 Calculation based on pooled 5-year rolling averages of data from the *Current Population Survey*, U.S. Census Bureau.

3 Some children have multiple sources of coverage. Therefore, the sum of privately insured children, those with government insurance, and uninsured children is greater than 100%.

4 Weissman, J.S. and A.M. Epstein. *Falling through the Safety Net: Insurance Status and Access to Health Care*. Baltimore: The Johns Hopkins University Press, 1994. p. 57, 87-91.

5 American College of Physicians-American Society of Internal Medicine. *No Health Insurance? It's Enough to Make You Sick*. White Paper. Philadelphia: American College of Physicians-American Society of Internal Medicine; 2000. (Available from American College of Physicians-American Society of Internal Medicine, 190 N. Independence Mall West, Philadelphia, PA 19106).

6 Louis Harris & Associates. *A Profile of Arizona's Chronically Uninsured Children*. (Mimeo.) Phoenix: The Flinn Foundation, 1998.

7 Kirkman-Liff, B. *Arizonans Without Health Insurance*. (Mimeo.) Tempe: School of Health Administration and Policy, Arizona State University, 1996.

8 Weissman, J.S. and A.M. Epstein. *Falling Through the Safety Net: Insurance Status and Access to Health Care*. Baltimore: The Johns Hopkins University Press, 1994. p. 135.

9 The Federal Poverty Levels are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The 2000 Federal Poverty Guidelines are published in the *Federal Register*: February 15, 2000 Volume 65, Number 31, pp. 7555-7.

10 American Academy of Pediatrics Division of Health Policy Research. *Program Eligibility of Uninsured Children through Age 18, Year 2000 Projection*. Elk Grove Village, IL: American Academy of Pediatrics; 1999.

11 Sheils, J. and P. Hogan. Cost of Tax-Exempt Health Benefits in 1998. *Health Affairs*. 1999. 18(2): 176-181.

12 Calculations based on data from: Kirkman-Liff, B. *Health Insurance Coverage in Arizona: A Detailed Analysis*. (Mimeo.) Tempe: School of Health Administration and Policy. Arizona State University, 1996. p.16.

13 Annual Supplement, *Current Population Survey*, U.S. Census Bureau, March 1999.

14 Lizka, D., et. al. *State-Level Databook on Health Care Access and Financing*. Third Edition. Washington, DC: The Urban Institute Press, 1998. pp.52-55.

15 Ibid.

16 Cooper, P. and B. Schone. "More Offers, Fewer Takers For Employment-Based Health Insurance: 1987 and 1996." *Health Affairs*. 1997. 16(6): 142-149.

17 Kirkman-Liff, B. *Health Insurance Coverage in Arizona: A Detailed Analysis.* (Mimeo.) Tempe: School of Health Administration and Policy. Arizona State University, 1996. p.16.

18 U.S. GAO. *Health Insurance for Children: Declines in Employment-Based Coverage Leave Millions Uninsured, State and Private Programs Offer New Approaches.* GAO/T-HEHS-97-105. 1997.

19 *Ibid.*

20 Madden, C.W., and A. Cheadle, et al. Voluntary Public Health Insurance for Low-Income Families: The Decision to Enroll. *Journal of Health Politics, Policy and Law.* 1995. 20(4): 955-972.

21 Ku, L. et al. *The Use of Sliding Scale Premiums in Subsidized Insurance Programs.* Urban Institute. March 1997.

22 COBRA, or the Consolidated Omnibus Budget Reconciliation Act of 1985, provides an employee who resigns or is terminated from a job for any reason other than "gross misconduct" the guaranteed right to continue health coverage through his former employer's group health plan for a defined term at the employee's own expense.

23 Fronstin, P. *Features of Employment-Based Health Plans.* Employee Benefit Research Institute Issue Brief Number 201. September 1998.

24 U.S. GAO. *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators.* GAO/HEHS-98-67. 1998.

25 Medicaid is governed by, and funded through, Title XIX of the Social Security Act.

26 The Direct Service option in the KidsCare plan allows families to access services at a selected group of community-based clinics and hospitals. This option does not include coverage of emergency services or behavioral health services.

27 American Academy of Pediatrics Division of Health Policy Research. *Program Eligibility of Uninsured Children through Age 18, Year 2000 Projection.* Elk Grove Village, IL: American Academy of Pediatrics, 1999.

28 In order to qualify for Medicaid, an adult must earn less than 35% of the FPL, and be blind, disabled, or have a family that includes a child "deprived of parental support due to absence, death, disability, unemployment or underemployment."

29 No Community Health Centers are located in Apache, Graham, Greenlee, La Paz, and Mohave counties.

30 For further discussion of the impact of funding on service delivery, see Mental Health Dissemination Network of Arizona. *Into the Light: A Search for Excellence in Arizona's Behavioral Health System.* White Paper. Phoenix: St. Luke's Charitable Health Trust. December 1999.

31 ValueOptions. *Analysis of Service Gaps in the Behavioral Health Delivery System.* Phoenix, AZ: Maricopa County Regional Behavioral Health Authority. 1999.

32 WIC is the state and federally funded Special Supplemental Nutrition Program for Women, Infants and Children.

33 Verbal communication, Mike Humphrey, Pima County Health Department.

34 COBRA (Consolidated Omnibus Budget Reconciliation Act), OBRA (Omnibus Budget Reconciliation Act), and EMTALA (Emergency Medical Treatment and Active Labor Act), "Anti-dumping law", Section 1867 of the Social Security Act, Section 9121 of COBRA. All refer to material codified at 42 U.S. Code, Section 1395dd.

35 National Conference of State Legislatures. *Access to Primary Health Care: Tracking the States.* 1998.

36 Because medical staff and services are limited in many IHS clinics and hospitals, some Indians sign up for other health care programs. However, some of these individuals continue to obtain periodic health care services at IHS clinics and hospitals. Until recently, IHS has had difficulty recouping any of the costs for that care from the individual's primary insurance carrier. Recent policy changes should improve this problem.

37 Arizona Department of Economic Security. September 1, 1998.

38 Arizona Department of Health Services. (1990). *Arizona Cooperative Agreement Application Fiscal Year 1990-1991.*

39 Hall, A.G., et al. *Employer-Sponsored Health Insurance: Implications for Minority Workers.* White Paper. New York: The Commonwealth Fund. February 1999

40 Annual Supplement, *Current Population Survey*, U.S. Census Bureau, March 1999.

41 Bureau of Primary Health Care, U.S. Department of Health and Human Services
www.bphc.hrsa.dhhs.gov/databases/hpsa/

The Healthy Children Arizona committee analyzes the complex issues involving children without health insurance. Through this project, Children's Action Alliance works to build consensus on strategies that increase health care coverage and improve maternal and child health throughout Arizona.

We are grateful to the members of the Healthy Children Arizona committee for their dedication to reducing the number of uninsured children in Arizona.

Healthy Children Arizona Committee

Hugo Aguirre
Yuma County Department of Public Health

William Baker
St. Luke's Charitable Health Trust

Barbara Burkholder
Arizona Public Health Association

Cheryl Collier Becker
Mental Health Association of Arizona

Janelle Degn
Phoenix Day Child and Family Learning Center

Lynn Dunton
AHCCCS

Elsie Eyer
Arizona Department of Health Services

Robert Ganelin, M.D.
Arizona Chapter, American Academy of Pediatrics

Felipe Gonzalez, M.D.
Arizona Chapter, American Academy of Pediatrics

Rory Hays
Attorney-at-Law

José Hernandez
El Rio Community Health Center

Carol Kamin, Ph.D.
Children's Action Alliance

Judy Keagy
Children's Clinics for Rehabilitative Services

Brad Kirkman-Liff, Ph.D.
ASU School of Health Administration and Policy

David Landrith
Arizona Medical Association

Gifford Loda
St. Joseph's Hospital and Medical Center

Linda Lopez
El Rio Community Health Center

Steve Lynn
UniSource Energy Corporation

Sharon Mahedy
Health Links

Debbie McCune Davis
The Arizona Partnership for Infant Immunization

Alida Montiel
Inter Tribal Council of Arizona

Kelly O'Connor
Community Food Bank

Jane Pearson
St. Luke's Charitable Health Trust

Phyllis Primas
ASU College of Nursing

Mary Rimsza, M.D.
ASU Student Health

Andy Rinde
Arizona Association of Community Health Centers

John Rivers
Arizona Hospital and Healthcare Association

Diane Ross
AHCCCS

Norm Saba, M.D.
Arizona Chapter, American Academy of Pediatrics

Terrence Slaven
Phoenix Children's Hospital

Judy Walruff
The Flinn Foundation

Ginger Ward
Southwest Human Development

Susan Watchman
Gammage and Burnham

Vince Wood
Department of Economic Security

Children's Action Alliance

Statewide Office

4001 N. 3rd Street, Suite 160
Phoenix, AZ 85012
Tel. 602-266-0707
Fax 602-263-8792
E-mail: caa@azchildren.org
Web address: www.azchildren.org

Southern Arizona Office

3610 N. Prince Village Pl., Suite 100
Tucson, Arizona 85719
Tel. 520-795-4199
Fax 520-795-3409